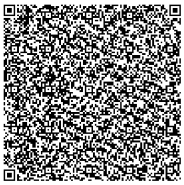

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A Neglected Dimension of Medical Tourism Destination Impacts: A Synthesis of Observations and Convictions

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Abstract

Medical tourism based on transnational journeys for health care, cure, and well-being is being widely discussed in the literature. As a fast-developing phenomenon, there are different views and perspectives on the concerns of medical tourists and various impacts created in destination areas. This paper critically observes the exertions of medical tourism on destination areas in the light of economic and socio-cultural influences. This paper tries to bring out the muddles of the phenomenon based on empirical research. The paper suggests that the socio-cultural impact of medical tourism on the health care of the poor local people must be viewed seriously and calls for rigid and efficient legislation from the authorities to enable and strengthen the public healthcare system.

Keywords: Medical Tourism, Medical Tourists, Medical Tourism Facilitators, Brain Drain, Public Healthcare

1. Introduction

Media, practitioners, researchers and healthcare industries are optimistically viewing the new niche, Medical Tourism. It has been noted that for the past few years, people seeking healthcare are inclined to travel from advanced countries to developing or even to

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underdeveloped countries. The earlier pattern of movement for medical care has been transformed into medical tourism packages wherein some stakeholders actively participate in a single cause-hassle-free healthcare and cure abroad. This new trend has now been referred to as medical tourism which is emerging as a unique and readily identifiable form of tourism and those who undergo treatment abroad are referred to as Medical tourists. Medical tourists travel mainly for cheaper and quicker treatment options which are equal to or better than that of their home country/ destination (Horowitz & Rosensweig, 2007; MacReady, 2007). The possibility of medical care destinations has been extended to countries like Thailand, India, and Mexico. According to Solomon (2011), Medical tourism is a boon for the desperate and needy who suffer from severe ailments and hindering situations. McKinsey (2008) (cited in WHO Bulletin, 2013) classified Medical tourists on the basis of their primary motivations like most advanced technology, better quality care, quicker access cost-benefit, and discretionary treatments. However, the subsequent Medical Tourism Association Survey (2013) found that the cost-effectiveness factor itself arouses 80% of the demand for medical tourism. It grows at a higher pace and has become an essential segment of the healthcare industry and is promoted by the stakeholders with its competitive advantages. All over the world, it has become a niche and a prominent portfolio in tourism and other sectors of the economy (Joseph, 2016). It turned out to be a prospect of a trade for all the stakeholders involved than ever before and is seeking every opportunity to stand at the helm.

Medical tourism has attained a national industry status in more than 50 countries (Rad et al., 2010). The average contribution of the industry accounts to $45 - $95 billion to global Gross Domestic Product (GDP) for six million patients (Medical Tourism Association, 2013). The average spending of a medical tourist is higher when compared to a leisure tourist (Bennet et al., 2004). WTTC (2011) accounted that the average spending of a medical tourist is USD 12,000 while a leisure tourist spends only US$ 6383. Subsequently, Medical Tourism Association (2013) also asserted that average spending is between $7,475 and $15,833 per medical travel trip which means a Medical tourist spends approximately twice money in the destination country. Viewing this financial

aspect, both the governments and stakeholders are increasingly interested in medical tourism activity.

2. Purpose of the Study

Now along with its fast development phase, the industry witnesses many arguments favouring and criticising Medical tourism. The industry is vulnerable as it handles human life and its fast development places immense pressure on the key players and destination area. Many are mere speculations based on little evidence, and some are serious issues which must be debated upon. The available literature on Medical tourism falls into both categories yet these issues remain as it is because of the peculiar nature of the phenomenon and the industry. Hence, this study aims to discuss the various challenges faced by the destination area, in general, regarding its direct and indirect impacts as a result of Medical tourism development.

3. Objectives

1. To describe the generic impacts of Medical tourism with reference to modern medicine
2. To identify the various impacts of Medical tourism development in the context of Modern medical treatment in Kerala.
3. To propose sustainable medical tourism practices with reference to modern medicine.

4. Methodology

This article is based on an extensive review of the relevant literature available on the various impacts of medical tourism on the destination area. To supplement the review, the results of the qualitative inquiry using semi-structured questionnaire with Medical Tourism Hospital authorities and Medical Tourism Facilitators are also included. The verbatim is also contained wherever necessary. Due to the confidential nature of the industry, the interviews with different types of stakeholders were required to unveil the real impacts of medical tourism. Hence, 17 Hospital

authorities (09 Allopathy hospitals with minimum 50 beds, 5 Dental Clinics and 3 Eye Care hospitals) and 14 Medical Tourism Facilitators (2 medical tourism companies, 7 travel agencies who act as inbound Medical tourism operators and 5 Medical tourism freelancing agents) from Kerala were interviewed.

This paper is presented in such a way that the literature review and the results of qualitative inquiry supplement each other to fill the research gaps. This study concentrates on the possible economic, environmental, socio-cultural, and destination dimensions of the impacts considering the inherent characteristics of medical tourism niche. The literature review fills the gap wherever necessary. The study was conducted in Kerala, India from October 2014 to May 2015.

5. The Exertions of Medical Tourism on the Destination Area

5.1. Denial of healthcare access to the poor through the public sector

Due to the geographical nature of Medical tourism, it is the destination which has all gains and, of course, the direct and indirect aftermaths too. Some researchers (e.g., Cohen, 2011; Turner, 2007; Riesman, 2010) have observed the different aftermaths of MT and have argued that it will sideline the public healthcare sector. Though it contributes to the national GDP, the public sector does not get the contribution (Cohen, 2011) and hence researchers like Bennett (2009) and Connell (2013) reject the argument of medical tourism as an economic boon to the destination area and residents. Further, Connell (2013) pointed out that Medical tourism has deteriorated healthcare access, notably, sidelining the rural population in several parts of Asia, resulting in growing inequity in healthcare. Countries which are actively promoting this new phenomenon are facing a more acute situation where public health funding has been reduced gradually while continuing in commercial patterns of health care system (Kristen & Smith; 2008; Smith, 2012). It challenges rather than supplements the local health caregivers, distorts national health care systems, (coincided with the ascent of neo-liberalism) and raises domestic, economic, ethical, and social anomalies that may easily increase

treatment costs, as it has done in Thailand (Connell, 2013). Further, Bookman and Bookman (2007) observed that:

> More often than not, in developing countries where medical tourism nourishes, basic health care for rural populations and the urban poor is rudimentary. A dual medical system has emerged in which specialisation in cardiology, ophthalmology and plastic surgery serves the foreign and wealthy domestic patients while the local populations lack basics such as sanitation, clean water and regular deforming. (p. 7)

Similarly, Bookman & Bookman (2007) pointed out that in Cuba, "only one-fourth of the beds in CIREN (the International Centre for Neurological Restoration in Havana) are filled by Cubans and so-called dollar pharmacies provide a broader range of medicines to Westerners who pay in foreign currency" (p. 177). Likewise, Haaretz, a newspaper of Israel reported that:

> medical tourists enjoy conditions Israelis can only dream of, including very short waiting times for procedures, the right to choose their doctor and private rooms . . . [a]nd these benefits may well be coming at the expense of Israeli patients' care. (Even & Zinshtein, 2010, p. 1)

It can be observed that in India and Thailand where MT has been one of the primary service industries, the entire health system is two-tiered; private for the elite including medical tourists and public for the poor residents (Connell, 2013). Sengupta & Nundy (2005) stated that in India, the poor have to approach the private laboratories and pharmacies as the lab services are not available in public-sector hospitals. Here it is to be noted that the outpatient consultancies of a public-sector doctor are more than 100 in a single stretch (Sengupta & Nundy, 2005).

Transparency International Survey found that 30% of the patients had to offer payoffs or use power to get an appointment with senior physicians and to get treatment after jumping the long queues of public healthcare institutions (Sengupta & Nundy, 2005). In Israel, which has seen a big boost in Medical tourists, waiting times are shorter for them than those for local people, especially in areas such as in vitro fertilization (IVF) (Connell, 2011). In

Thailand, cardiac patients have to wait longer in public hospitals as doctors are seen to be shifting to the private ones. This is expected to increase further with the ageing population (Phanayang-door, 2006 cited in Connell, 2013). In the same way, Cohen (2008) observed that:

> A Thai doctor observed in 2006: each time a foreigner sees a Thai doctor at "foreigner prices" he takes away an opportunity for a Thai person to see the same doctor at standard Thai fees. In other words, this programme, while presumably bringing foreign capital to our hospitals, is sucking medical care from our own people. (p. 250)

There is a 'Fast Track System' in Kerala, India that gives free treatment to Medical tourists to avoid waiting time. There is a separate queue or 'intangible queue' for a backdoor entry to the consultation room. The intermediaries decide the access of Medical tourists to the doctor. Unfortunately, the locals have to wait outside desperately without even knowing the existence of a back-door. The study found that even with moderate development in Medical tourism development, the impact is felt in Kerala with the interference of the Medical Tourism Facilitator. In every such hospital, the queue before each consultation counter resembles the queues for cine theatre tickets. "Waiting times for ordinary Israelis will inevitably lengthen — especially in the departments most frequented by medical tourists, which include cancer, cardiac and in vitro fertilisation units" (Even & Zinshtein, 2010, p. 1). Similarly, Ormond (2011) observed that:

> Dr Teoh, the former chair of the MMA (Malaysian Medical Association) who served on the National Committee for the Promotion of Health Tourism when 'medical tourism' was first put on the development agenda has observed that: while it [medical tourism] may offer glamorous profits to the private sector . . . Healthcare is a social service and remains within the public sector. We must first serve the needs of our populace and, until we do so, public resources should not be diverted for whatever economic purposes. All these actions will have medium- and long-term effects on the public health sector unless there are corresponding

actions to balance. Many of our people are still deprived of quality health services. (p.7)

Likewise, according to Nash (2009, cited in Connell 2011):

> "While India's public sector health-care and sanitation systems are indeed mostly detached and distinct from medical tourism, they are all part of a national political economy. Even within hospitals, as in Thailand, differences between the private medical tourism sector and the public sector can be considerable. Phuket International Hospital, for example, has an air-conditioned wing for medical tourists 'with the sleek furniture and lush floral arrangements of a boutique hotel. . . flat screened TVs and views of manicured gardens', but after the writer took a wrong turn, she arrived 'in the public ward, 40degrees hot and packed with "real" people"(p. 16–17).

5.2 Who does the government support- private or public sector?

World Health Organisation (WHO) has pointed out that Medical tourism will sideline the public healthcare by cutting recruitment levels, slashing staff quality, and increasing public sector salary costs (Bennett, 2009). Unfavourable effects of Medical tourism will be of many kinds. It will result in inflated rates for treatments for local patients. With increasing national support for the industry by extensive promotion and marketing, provision of land and supportive tax advantages may concurrently weaken support and lessen public healthcare resource allocation (Connell, 2013). The Indian medical industry is provided with tax rebates; the government assists private healthcare institutions treating foreign patients such as lesser import duties and better rate of depreciation (from 25 per cent to 40 per cent) for life-saving medical equipment (Sengupta & Nundy, 2005). Prime land is allotted at reduced rates (Sengupta & Nundy, 2005). Ministry of Tourism helps in promotion by way of providing and circulating marketing materials such as CDs, pamphlets, brochures, and other directories to stimulate health and tourism in India among the all targeted areas (Sharma, 2013). A broad health care policy is aimed at for the tremendous

growth of the industry including new medical equipment or technology (Sharma, 2013). Medical tourism has been mainly promoted on different platforms abroad like World Travel Mart, London and ITB, Berlin (Sharma, 2013). Market Development Assistance (MDA) introduced by the Ministry of Tourism in 2009 aimed to financially assist different stakeholders to participate in fairs/medical conferences/wellness conferences/ wellness fairs and road shows (Sharma, 2013). Private sector growth in health is subtly stimulated while public hospitals suffer due to the insufficiency of funds (Ramesh & Xun, 2008). In its Union-Budget 2011-12, the Government of India had attempted to excuse the pharmaceutical sector from different direct and indirect taxes (Sharma, 2013). 59% of Indian doctors (73% allopathic) are in cities, particularly metropolitan areas (Jan Swasthya Abhiyan, 2006) where corporate hospitals become their asylum. Mudur (2014) criticised saying, "Where is the logic of the government spending energy and effort to attract foreign patients to the private sector when an overwhelming majority of patients in India have inadequate access to healthcare" (p. 1). As of now, none of the public-sector hospitals in India promotes medical tourism and the logical question then is 'who is benefitted?'

According to Chinai and Goswami (2007):

> While Indian private sector hospitals argue that private payments for medical care, and hotels and other services, will trickle down and benefit the economy as a whole, there is minimal evidence of this, in the absence of effective taxation policies, and unless more revenue is allocated to public health systems impacts will be negligible. (p. 165)

Evidence till date is clear that these hospitals have not respected the ethical and moral concern for receiving public funds and subsidies regarding treatment of a certain number of patients (both in-patients and out-patients) free of cost (Jan Swasthya Abhiyan, 2006). Furthermore, special tax concessions have been given to Medical tourism service providers and to tourism offices promoting medical tourism in Malaysia and Thailand, while governments are seemingly unaccountable for providing healthcare services to the poor (Connell, 2013).

5.3. Brain Drain

The shifting of trained and experienced medical specialists from the public sector to the competitive private healthcare sector thereby sidelining the health needs of local people is referred to as 'brain drain'. Pocock & Phua (2011) criticised the brain drain aspect especially when the trained medical staff at the cost of public funds for MT hospitals (Pocock & Phua, 2011; Cohen, 2011). Sengupta & Nundy (2005) accounted that this type of brain drain will give an indirect incentive of $90 to $110 million to the private healthcare sector. The availability of medical service in rural areas is not enough in countries like India and Thailand, and hence many people are travelling to urban cities in search of better treatment options. Connell (2013) referred doctors in the rural areas of India and Thailand as 'ghost doctors': present on the records and earning pays but never actually there' and criticises the absence of medical facilities for contagious diseases in the remote villages of some states in India. There is a growing trend among professionals to work with the private sector where salaries, work culture and fringe benefits are attractive (Connell, 2011). Bennett (2009) noted that there was a shift of doctors about 30 per cent in 1997 (from 8 per cent in 1994) from the public sector to the private when Thailand established policies for the promotion of Medical tourism by investing in private hospitals. The same shift has occurred in Malaysia as well so that 'the demand-supply deficits in healthcare human capital resources in the rural region the poor states in Malaysia are expected to be aggravated further' (Rasiah et al., 2009, p. 60 cited in Connell, 2013). The private hospitals own 20% of Malaysia's hospital beds while 54 % of the Malaysian doctors are practising in private hospitals which have severe repercussions on the healthcare sector such as lack of senior doctors in different specialists to teach and train the government medical students (Bennett, 2009). Again, in India, the primary health centers are running short of specialists such as obstetricians and Gynaecologists (56%), pediatricians (67%), surgeons (56%), and medical specialists (59%) (Sharma, 2013) where all specialities remain filled in with doctors in all public-sector hospitals.

Medical tourism as motivation to "internal brain drain" is illustrated in Thailand and Malaysia as they are boosting the

industry through global advertising, tax incentives, and assistance for training of medical personnel in local establishments and speciality fellowships overseas (Bennett, 2009). According to Sengupta & Nundy (2005), "when medical staff trained in public institutions for fees of about 100 Rupees ($11), a month move to work in private healthcare represents indirect support for the private sector of some 4000.-5000m Rupees per year" (p.1158). Exclusively for medical tourism, in Mexico, bilingual nurses may be trained using national resources (Connell, 2013). In Malaysia, over the last three decades, where the government has been acclaimed for health-care regulation, financing, and provision, is now been criticised for stepping away from welfares policies for the common man fostering the private health-care sector (Ormont, 2011). This notion is emphasised by Whittaker (2008) that apparently 'no-one' now wants to be involved in local primary and preventive health care. Instead of creating welfare by improving the social, political and economic determinants of health, Medical tourism has strengthened privatisation together with technological and medicalised perspectives on the health system where medical facilities and services can be availed 'off the shelf' (Connell, 2013). Medical tourism, for a country like India - the fifth most privatised health system in the world - is a misplaced priority and amounts to subsidising the medical needs of developed countries using scarce national resources (Jan Swasthya Abhiyan, 2006). Over the years, governments may be forced to grant them more substantial subsidies and exemptions for promoting medical tourism eventually making stress on public funds and subsidies (Sharma, 2013).

Even though some arguments are favouring Medical Tourism as a cause for a reversal of brain drain, there is no chance rather evidence to have them in the public sector hospitals. Medical and paramedical staff will come back to the home country provided they can work in private corporate hospitals earning more financial benefits. The largest corporate hospital chain in India, the Apollo Hospitals claims that they have more than 120 skilled medical professionals returned from other countries (Cortez, 2008). Nonetheless, the extent of the reverse brain drain is only a small fraction of the outbound current of skilled doctors from India to the US alone (Connell, 2010). In many countries such as India, the shift

of public doctors cannot be replaced just because of the termination formalities of the health professionals and recruitment of new ones eventually making a vacuum. Connell (2013) viewed this migration as a continuation of past phenomenon of migration from regional areas. It is quite natural that doctors, nurses and other paramedical staff move to the corporate hospitals to get good pay and other incentives to compensate for the heavy workload and the professional risks involved. From Kerala, being a source destination of health professionals in India, many doctors, nurses and paramedical staff have been shifting to metros and overseas in search of better payment options and living standards for many decades. The backbone of the Kerala economy is the foreign money earned by these professionals. Now medical tourism aggravates the situation.

5.4 Domination of the Private Sector

It is true that the privatisation of the healthcare sector has brought revolutionary changes. However, 'accessibility and affordability' for the poor is the real muddle. Sengupta (2011) pointed out that there is proof of discrepancy taking place in the corporate-run pharmaceutical sector, which aspires to aim the elite. The huge money earned from medical tourism is accumulated by the stakeholders involved - hospitality and hospital industry. It is found that, in Kerala, 100% of the medical tourism hospitals are in the private sector and more and more hospitals are seeking every opportunity to exploit the possibility of the industry. The expertise gained from the industry is likely to benefit the elite at private hospitals and do not affect the healthcare delivery to the poor (Connell, 2013). One of the major problems of medical tourism may be the uneven syphoning of technology to the private healthcare sector (Morgan, 2001). India ranks among the top twenty countries in the world in its private spending at 4.2% of GDP (Sengupta &Nundy, 2005). In 1947, the private healthcare sector provided 5 - 10% of total patient care when India became independent of British rule while today it accounts to 82% of outpatient visits, 58% of inpatient expenditure and 40 % of births in institutions (Sengupta &Nundy, 2005). The potential profits of healthcare industry lure many. Now, the turn is for MT. In Kerala, many private hospitals secured accreditations including JCI (Joint Commission

International) and NABH (National Accreditation Board for Hospitals) to increase the volume of MTs (Joseph, 2016).

5.5 Commercialisation of Services and Profiteering

The medical tourism healthcare providers are suspected of commercialised services and increased rates. 'Health' is marketed through websites and other sales promotion activities with a surname' tourism' and are often sold as 'package'. There is no uniformity in cost and quality across hospitals and are competing with each other as in the case of any other commodity. For example, in India, liver transplantation will cost more in Chennai than in Cochin. Again, there is a vast difference in cost when treatment is offered to a foreign patient. It is found that, in Kerala, there is a considerable difference in costs from hospital to hospital in the medical tourism arena. The average cost for General Health Checkup is Rs.17622.22 with a standard deviation of Rs. 13093.265 (Joseph, 2016). The average cost for Knee Replacement is Rs. 311111.11 (standard deviation is Rs.179891.943), Hip Replacement is Rs.342857.14 (standard deviation is Rs. 88640.526), and IVF is Rs. 250000 (Standard Deviation is Rs.273861.279) (Joseph, 2016).

One of the primary reasons for the inflated rate is probably the massive amount of commission paid to MTFs by the Medical Tourism hospitals. In Kerala, 49.9% of MTs use the assistance of facilitators. Without them, Medical tourism is difficult in a different cultural setting, and this makes them indispensable in the market enabling them to bargain their commission even up to 40% of the total bill which will be reflected in the total in bills. According to one Medical Tourism Facilitator in Kochi:

> Commission is 10-15% on an average, depends on hospitals policy. However, the hospitals which are at the forefront of medical tourism are even giving 20% of the total bill. (Joseph, 2016)

Profiteering in various forms has become a regular thing in the industry. Even though medical tourists feel that there are inflated and hidden costs, the vast expenses back home force them not to bargain. This finally makes the healthcare providers keep the rate high. Health care access has been determined by the ability to pay (Turner, 2010). Medical Tourism, every so often, effects in the way

of broadening the gap between 'haves and have-not' (Tattara, 2010). In a study conducted by the vice presidents of Hospitals in Bangkok, James (2012) found that costs are fluctuating when the treatment is proceeding. While agreeing to the fact that individual cost of treatments will vary, there are hidden charges which will be unveiled only at the time of discharge.

"Add-ons" like premier accommodation facilities comparable to five-star hotels are offered. In Bangkok, medical tourism package of an operator with 5-star hotel accommodation has led many first-world patients to select South East Asia as a medical-related destination (James, 2012). The corporate hospital's management and doctors may be inclined towards more profitable treatments and specialities and, in turn, boost the development of 'deluxe hospitality hospitals' for the medical tourists eventually sidelining the public healthcare institutions. This will finally take away the medical care from the interests of hospitals. Instead, wellness tourism or mere tourism will come in to focus which is more lucrative. This will have a cascading effect. The demand for extremely technologised medicine in a few lucrative specialities also makes distortions within the health care system. These include 'cherry-picking,' whereby Medical Tourism hospitals give treatments which are highly profitable to them (Chanda, 2002). Pellegrino (1999) criticised the increasing profiteering in the healthcare sector as "physicians no longer look on patients as "theirs" in the sense that they feel continuing responsibility for a given patient's welfare" (p. 253)

This drift contrasts the Declaration of Alma Ata adopted at the International Conference on Primary Health Care in 1978 that called for the need for serious action by the world community to protect and aggrandise quality affordable healthcare for all. Since then, the commonly accepted goal for achieving "Health for All" for the member countries of the World Health Organisation is effective primary healthcare delivery (Tattara, 2010). In countries like India, primary care is the responsibility of the public sector where the private sector has an eye on tertiary or quaternary care. Kangas (2002, cited in Whittaker, 2008) suggested that 'good medical care should not be available only to the moneyed or the mobile' (p. 69).

5.6 Other Industry Level Concerns

Apart from the above issues, the most significant industry level concerns identified are destination issues, communication problems, problems in language translation, non-availability of ethnic food, cultural differences, and infrastructural limitations (Joseph, 2016). Whittaker (2008) condemned the contribution to the foreign debt due to the purchase of high-tech medical equipment for a few affluent patients and providing importance to the lucrative specialities while ignoring public health. Another concern is the illegal activity both by the destination players and the Medical tourists. The absence of adequate legislation gives a significant burden on the destination regarding safety, security and cultural issues. According to a dental doctor in Kochi (Joseph, 2016),

> One Canadian couple has taken away my (doctor) articulator that costs around Rs. 25,000. Soon, I had informed the local police, airport authority and I met the City Police Commissioner, my people went behind them and shown them to the police...no use, nothing happened. Finally, as a last resort, I called them and told them that I would report to the police. Next day, when I was not here in the hospital, they came and gave it here (clinic) after taking all its costly parts. Will it happen in any other country?

Again, lack of proper and strict legislation in the Medical Tourism industry will nurture illegal and unethical practices for making easy money thereby spoiling the destination credibility and image. A study on sustainable Medical tourism in Kerala brought out the fact that there are hospitals that market treatment for non-curable diseases. There are instances of the Medical Tourists becoming the victims of treatment trials. One Medical Tourism Facilitator from Kozhikode, Kerala observed that (Joseph, 2016),

> My patient aged 50 years was advised to do Treadmill Test (TMT) and the same day he was done the angiogram. The next day he was weak and in a couple of hours' time he died. It was due to the internal injury caused by the medical negligence while doing an angiogram. He was very healthy.

> The hospital was in a never mind attitude. We cannot work in this industry conscientiously.

6. Findings and Suggestions

6.1. Regulatory framework

Policies and regulations related to medical tourism industry are neither planned nor implemented in Kerala. In the regulatory vacuum, a lot of exploitation and unethical practices take place especially with regard to cost and treatment. Legal compliance like M-visa for surgical reasons is not enforced. Hospitals and medical tourism facilitators operate in the target market with a competitive mind and there is no benchmark in terms of marketing, product development, and pricing strategies.

There must be some system to regulate and monitor stakeholders continuously in order to maintain the safety aspects of medical tourists. There should be effective legislation to control the exploitation of private healthcare institutions. Setting up Medical Tourism Cells or Medical Tourism Kiosks at each destination/city is important. Medical tourists can get information as well as convey their grievances through them. A mechanism should be in place to assess the data and the direct impacts on the phenomenon through continuous research on a regular basis. Implementation of M-Visa on arrival (MVoA) is essential for the ease of medical tourism development.

6.2. Accreditation/ registration system

Accreditation should be made as an integral part of the system. All hospitals promoting Medical tourism should possess accreditation (dental/ ophthalmology council registration). Based on the type of accreditations like JCI (Joint Commission International), NABH (National Accreditation Board for Hospitals), KASH (Kerala Accreditation Standards for Hospitals), cost structures also can be standardised. Medical Tourism Facilitators must be held to high standards of practice if they are to be allowed to assist cross-border travel for health services (Turner, 2010). They must have certification in line with certification programmes of the Medical Tourism Association (MTA) for facilitators.

6.3 Quality embedded medical tourism system

The aspects like provisions for ethnic food, language interpretation and so on must be taken seriously. It is critical to promote the ongoing monitoring and evaluation of the quality of services predominantly focussing on the key dimensions of effectiveness, service quality, safety and patient centeredness. Setting up of a state-level system for evaluating the medical tourists' experiences is very important and feedback must be analysed with the help of modern technology for taking remedial measures. Total Quality Management (TQM) and Continuous Quality Improvement (CQI) should be made mandatory for stakeholders. This will ensure best patient experience and outcomes.

6.4 Aftercare

Continuity of care needs attention and should be considered as an integral feature of international medical travel. For aftercare, the possibility of telemedicine can be used.

6.5 Role of public sector

In Kerala, the medical tourism industry is dominated by the private sector. Kerala has the largest number of NABH accredited public sector hospitals in India. The expertise and experience of doctors in the public sector can be directed in such a way that medical tourists can access public healthcare which will directly result in the development of public healthcare infrastructure of Kerala.

6.6 Socio-cultural impact

Impact of Medical tourism development is felt in Kerala especially in terms of the domination of the private sector. Fast track system may adversely affect local patients and put them in long queues for accessing treatment. The government should make sure that Medical tourism does not affect local patients. On the other hand, they should be complimented with more access and facilities. Profiteering of private players including hospitals and facilitators has to be controlled.

6.7 Taxation policy

Medical tourism is viewed as a foreign exchange earner for the destination country and hence governments are forced to support

the industry with tax concessions, subsidies and so on. However, these resources are moving into the corporate hands which use them for profit making. This has a cascading effect on the economic and socio-cultural aspects of the host economy. Indeed, as an upcoming profitable niche, Medical tourism needs promotional support from the government in the form of subsidies and support. At the same time, the industry has to be taxed adequately to compensate the same. Only by doing so can the public sector health facilities improve with these financial resources.

7. Conclusion

Medical tourism development can create many negative impacts on the host community such as neglected public sector health system, denial of access to the poor, domination of the private sector, commercialisation and overpricing, brain drain and so on. It also creates various risks, after-care issues and malpractices. Kerala is yet to identify any major threats. Nonetheless, the fast track system of MTs may negatively affect local patients which will result in a long waiting time. Aftercare issues are felt slightly and malpractices and legal issues exist due to the absence of proper legislation and regulation of the industry. The industry is dominated by the private sector with a motive to make profits. There should be a conscious effort by policy-makers and stakeholders of each destination to market and promote unique and appropriate tourism products to each medical tourist to ensure convenient and comfortable rest after their treatment. A patient-focused approach while caring for the patient should be adopted without legal problems. Cross-cultural sensitivities must be handled with utmost care. Implementing medical tourism laws with emphasis on accidents and risks and advocating medical insurance portability is the need of the hour. The government should work on improving the infrastructure for public healthcare, increase its accessibility to the poor and prevent brain drain from the public healthcare sector. There must be a system to continuously regulate and monitor stakeholders in order to maintain the health and safety of Medical tourists. Along with enormous potential benefits, Medical tourism carries a lot of sensitive issues and risks to destination countries and beneficiaries thereby putting their lives at stake.

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